Integrating Systems of Care

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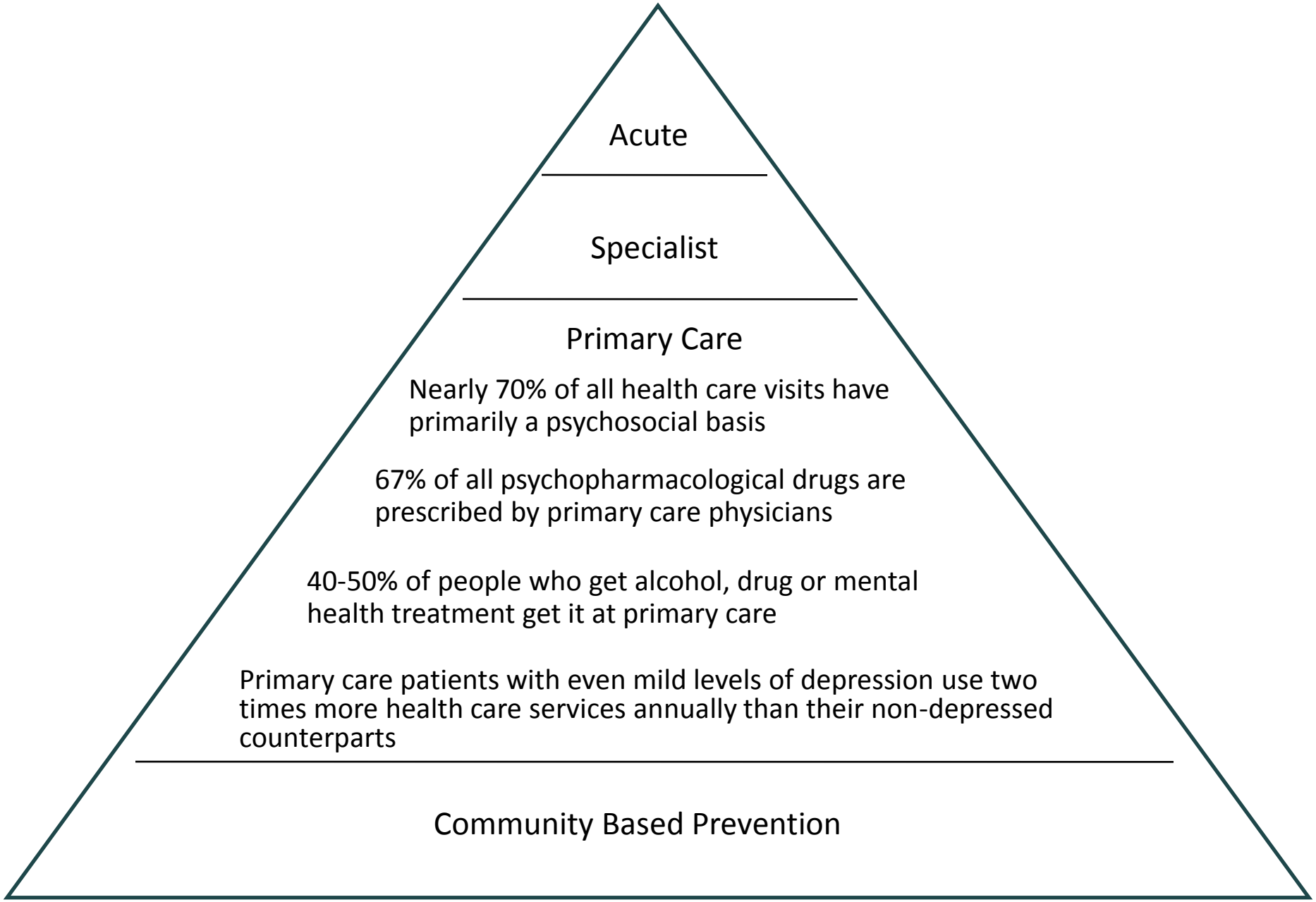
What are the potential setting?

- Primary Care
- Mental Health
- Substance Abuse
- Specialty


Acute
Specialist
Primary Care
Nearly 70% of all health care visits have primarily a psychosocial basis
67% of all psychopharmacological drugs are prescribed by primary care physicians
40-50% of people who get alcohol, drug or mental health treatment get it at primary care
Primary care patients with even mild levels of depression use two times more health care services annually than their non-depressed counterparts
Community Based Prevention

What types of providers

- Medical (Primary Care / Psychiatrists)
- Licensed Therapists
- Care Managers
- Community Health Workers

Four Quadrant Model

Low physical health includes prevention, screening for early intervention, well care and monitoring for a well controlled chronic condition provided by primary care.

Low behavioral health includes behavioral change necessary to maintain good health, mental health conditions and substance use that does not qualify for enhanced services and is provided by primary care or licensed behavioral health providers.

Four Quadrant Model

High physical health continues to include preventive primary care adding complex/unstable chronic and acute condition(s) provided by primary care and/or multiple specialists.

High behavioral health includes specialty MHDDSA services for the treatment of severe and persistent mental illness, developmental delays and substance abuse provided by licensed behavioral health and/ or psychiatrists and/or credentialed enhanced service providers

What are the possible models?

- Collaboration
- Colocation
- Integration

Collaboration

- Streamlined referral process
- Communication
  - Exchange of records and key information
  - Direct messaging
  - Informed plans of care
- Provider to provider consultations
- Defined responsibilities

Colocation

- Increased Access
- Shared Space
- Shared Scheduling
- Increased Screening

- Separate Appointments
- Traditional clinical services

Integration

- Joint appointment
- Clinical services change
- Share medical records
- Joint care plan

What is Integrated Primary Care?

Integrated Primary Care combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to primary medical care.

It is important to note that it is not a replacement for specialty mental health. Close collaboration with specialty mental health is critical to ensure that individuals with a severe and persistent mental illness receive clinically appropriate services which are increasingly community based.

Questions?

Integrated Care from a policy perspective

Because the vast majority of patients in primary care have either:

- a physical ailment that is affected by stress,
- problems maintaining healthy lifestyles,
- or a psychological disorder

it is clinically effective and cost effective to make behavioral health providers part of primary medical care.

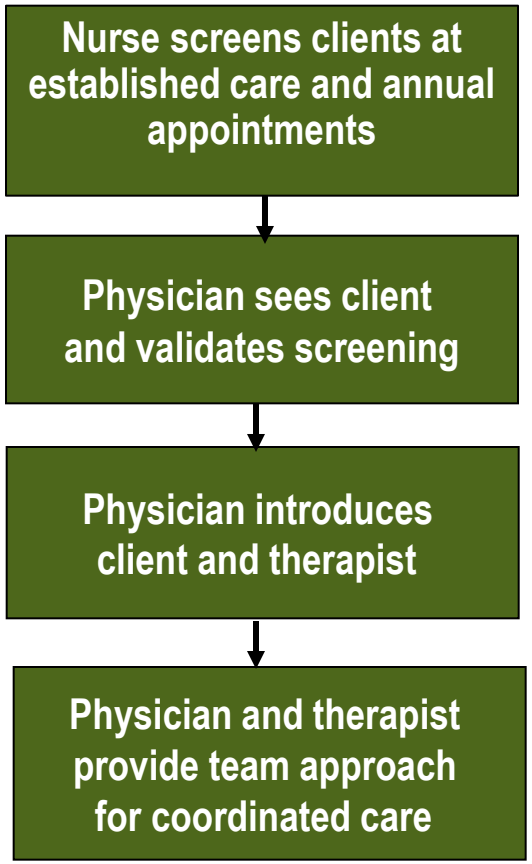
Objective

- Increase evidenced based practices
- Increase prevention and early identification.
- Improve treatment adherence
- Increase patient functional status & productivity
- Improve clinical outcomes
- Improve patient and staff satisfaction
- Decrease costs

What were our PCP's starting point

- Medical Home
  - Often coordinate the medical care of the individual completely unaware of the MH/SA treatment
  - Demand for primary care exceeds capacity
  - Fee for service does not promote team based care
- Self Management / Motivational Interviewing
  - Not maximizing techniques to motivate behavior necessary to achieving and maintaining good health
- Behavioral Health Services for low MH/SA
  - Fail to screen for underlying behavioral health conditions
  - They are the main prescribers, yet many have not adopted evidenced based treatment guidelines for common conditions like depression, ADHD, anxiety and substance use / misuse
- High MH/SA Access Issues
  - Due to the lack of psychiatrist they are increasingly asked to fill medications for which they have had minimal training

Integrated Care Model



- Screening
- Assessment
- Treatment guidelines
- Brief Interventions
- Brief Therapy
- Coordinated team care
- Case management
- Medication monitoring
- Referral and Linkage

*** Based on Chronic Care Model**

Behavioral Health Clinician Functions

- Brief Interventions (Disease specific or lifestyle changes)
  - Motivational interviewing
  - Development of self management plans
- Therapy
  - Short-term cognitive behavioral therapy
  - Intervene in crisis / linkage with specialist
- Monitor Clinical Pathway
  - Contact with patients to monitor progress
  - Re-assess; follow-up on symptoms
  - Assess functioning
- Medication management
  - Monitor medication adherence
  - Educate on side effects

Psychiatric back-up

- Adoption of clinical pathways
- Psychiatric evaluations/consultations
- Medication issues
- Review cases

Role of Care Manager

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High behavioral health includes specialty MHDDSA services for the treatment of severe and persistent mental illness, developmental delays and substance abuse provided by licensed behavioral health and/ or psychiatrists and/or credentialed enhanced service providers

Role of Community Health Worker

- Scheduling and assisting in appointment attendance
- Assuring access to social supports: transportation, housing, food stamps, support meetings..
- Supporting patient in follow through on self-management plan and goals
- Understanding the warning signs on a care plan

Questions?

Barriers to Integrated Care

- Organizational and professional culture differences between PC and BH providers
- Clinical and fiscal separation of physical and mental health care at the provider level
- Legal barriers to open communication between providers.
- Significant workforce issues
- Neither PCP / BHP had good understanding of the models needed for Primary Care
- Significant changes within our specialty mental health system

Practice Transformation

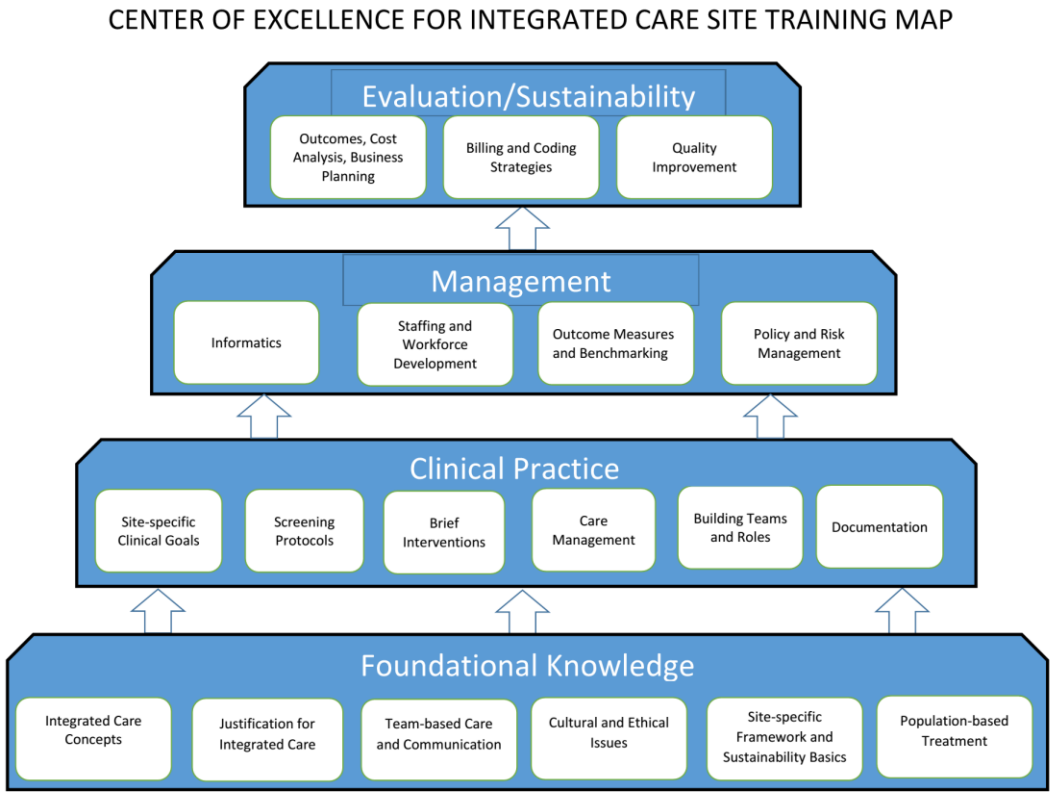
- Hire for fit
- New cultural exchanges
- New clinical pathways and skills
- Understand coverage / billing
- Significant practice redesign

What activities will need to occur?

- PCP and BHP education around mental health, medical and chronic conditions
- PCP and BHP to adopt evidenced-based pathways.
- BHP who function in a brief model for behavioral health, mental health and substance use.
- PCP / BHP to function internally as a team (clinical and operationally)
- Patients to show functional improvement
- Providers and patients to engage in the model
- Providers and the payers will need to make the model sustainable
- PCP / BHP to refer more complex patients to specialty mental health
- SMH communication, linkage and referral to PCP
- PCP / SMG to co manage complex patients

Fund on-site practice transformation

- Foundational Knowledge
- Clinical Knowledge
- Management
- Evaluation / Sustainability



NC Foundation for Advanced Health Programs – Center of Excellence (ncfahp.org)

Funding challenges

- Not understanding practice population - various insurance coverage
- Carve out for BHP
- Different payment models (FQHC)
- Uninsured and underinsured
- Lack of access to specialist
- Setting up a specialty model
- Co payments
- Not being in Network

Questions?

Policy

- Should drive the clinical model desired
  - Increase access
  - Allow for full range of scope
  - Should fit the type of practice
  - Define responsibility
  - Prevent abuse or misuse
  - Drive movement across the continuum

Medicaid Policy Changes

- Significant changes to existing policy and systems to support the integration of behavioral health providers into primary care.
- New codes for physicians / behavioral health providers when provided incident to as a member of the team. (Screening, tobacco, SBIRT, Health and Behavioral Assessments)
- New codes do not count toward physical or mental health visit limits
- Mandate a limited number of brief therapeutic sessions
- Significant separation at the larger system level.

  (Policy, Coding, Prior Authorization, Provider Type and Edits, Rules)

Get in the claims payment weeds.

- What does the pm/pm cover?
- Can multiple policy be implemented?
- How do edits work across different practices?

The use of EHR to support integration

- Direct messaging for collaboration
- Build MH diagnosis in registries
- Advocate for MU and/or help fund MHA to get EHRs
- Support connectivity efforts
- Shared plans of care
- Clarify privacy laws
- Support efforts to adopt EHR platforms that support integrated care
- HIT for dashboards and impact

Specialty Mental Health

- Accessing Primary Care for the SPMI population.
  - Dying from untreated medical conditions
  - Less likely to receive preventive care
  - High rate of tobacco dependency
- Collaboration
- Colocation
- Integration

Leveraging Government Agencies

- NC DHHS increasingly work internally and externally to promote integration
  - Increase services in Emergency Departments
  - Alignment between care management programs
  - Funding EHR and HIE efforts
  - Loan repayment as a tool
- Federal government increasingly paying attention to this
  - HRSA / SAMPSA Integrated care site
  - Certified Community Behavioral Health Clinics
  - Still challenges (block grants, SA law)

Other key partners

- Private insurance is interested but not yet fully investing in moving the model forward
- Coverage is currently not comprehensive
- Higher educational systems training curriculums must change.

Questions?

Thank you

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